

exercises. Our key objectives were to 1) facilitate engagement of stakeholders and modelling teams, 2) develop a shared understanding of the current implementations of the NHS HCP, 3) identify what is working well and less well, 4) identify future hopes for the NHS HCP, and 5) explore features and specifications to potentially include in a useful decision-support tool for stakeholders.

Results Fifteen key stakeholders participated in workshop 1. They spanned all levels: local (NHS commissioners, GPs, academics), third sector organisations and national organisations (including PHE and NICE). This diverse mix of stakeholders provided a rich diversity of perspectives. Stakeholders agreed that there is continued (financial and political) support for the NHS HCP. However, many stakeholders highlighted issues with the lack of data on processes and outcomes, variety in quality of delivery and suboptimal public engagement. Stakeholders' hopes for the programme included maximising coverage, uptake and appropriate referrals, and producing additional evidence on population health, equity and economic impacts. Stakeholders suggested several useful features including focusing on feasible NHS HCP implementations based on good-practice template scenarios, analysis of broader prevention activities at local level, accessible local data, broader economic perspectives and fit-for-purpose outputs. These results then informed the objectives for the second and subsequent project workshops, which will include sharing and refining a prototype user interface, and exploring different scenarios to be evaluated.

Conclusion This project includes innovative approaches to engage with key stakeholders via Hovmand style workshops. These potentially offer an effective participatory method for involving stakeholders in the process of understanding a complex problem, and collaborating in the joint development of a decision-support tool focused on the needs of the final users.

P32 **REALISING THE POTENTIAL OF THE WIDER PUBLIC HEALTH WORKFORCE: CAUTIONARY TALES FROM THE EVALUATION OF PROGRAMMES TO EXTEND THE ROLE OF FRONTLINE STAFF**

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Rationale After the move of responsibility for public health to local government in 2013, Public Health England estimated there were 15 million people in the wider workforce who could potentially contribute to health improvement. In order to inform future initiatives to develop and extend the public health role of the wider workforce, we analysed data from the evaluation of two programmes designed to enhance the health promotion role of council employees, from a range of occupational groups. We explored the issues that need to be addressed to ensure this potential public health capacity can be appropriately harnessed.

Methods Qualitative data was collected from a) 12 staff focus groups undertaken during evaluation of 'Making Every Contact Count' (MECC) training offered to council staff b) in-depth interviews with 21 neighbourhood housing officers undertaken for the evaluation of a new 'Housing+' service, which required them to provide holistic health and wellbeing advice to council housing tenants. The data was analysed thematically to identify potential barriers and facilitators to the

engagement and development of the wider public health workforce.

Results The sample included staff from ten occupational groups with a wide range of roles and experience. Whilst most staff were positive in principle about engaging with health and wellbeing issues, occupational groups varied in their attitudes to the appropriateness of taking on a specifically health promoting role and a range of barriers and obstacles were identified. Obstacles included a lack of time and opportunity costs; conflict with other roles such as managing complaints and rent arrears; lack of capacity in other services they could refer clients to when urgent needs identified; and a concern they were being expected to replace other overstretched or non-existent community services. The range of views expressed on the feasibility and appropriateness of engaging clients or customers in discussion of health and wellbeing related issues, particularly health-related behaviour, suggested that implementation of training received, and the delivery of an extended role more generally, was likely to be highly variable.

Conclusion If the potential contribution of the wider workforce to maximising population health is to be achieved, the best way to engage staff and develop their role is likely to vary between occupational groups and the opportunity costs, potential unintended consequences and additional training needs must not be underestimated. Effectiveness and cost-effectiveness cannot be assumed in the absence of evaluation of the wider impact of role development in terms of both intended and unintended consequences.

P33 **WHAT DO DOCTORS KNOW ABOUT THE CLINICAL COURSE OF RECOVERY FROM COMMUNITY-ACQUIRED PNEUMONIA?**

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Background Community-acquired pneumonia (CAP) poses a significant clinical and economic burden in the United Kingdom, with an annual incidence rate of 0.5%–1% in adults. The mortality rate upon hospitalisation ranges between 5%–30%. Return to baseline health following CAP can surpass the expected timelines of recovery, with respect to duration and symptom resolution. Little is known about doctors' knowledge in this area. Therefore, this study provides a previously unexplored qualitative insight into doctors' views and knowledge of the clinical course of recovery in patients with CAP, following discharge.

Methods Ten one-to-one semi-structured interviews were conducted with junior doctors, who had experience in managing patients with CAP. Interviews were recorded and transcribed verbatim. Data was analysed using thematic analysis, with a predominantly inductive approach.

Results Whilst doctors maintained consensus on their proficiency in diagnosis and treatment, their knowledge and awareness of clinical recommendations for post-discharge care were less comprehensive and definitive.

No patient information resources on the recovery process from CAP were mentioned, even though many believed this would be beneficial. Similarly, doctors highlighted a lack of

awareness and/or availability of targeted support services to aid patients with their recovery.

Doctors are knowledgeable to varying degrees about the impact of the recovery process on patients. When managing patient's expectations of recovery, it is evident that doctors provide general advice based on their clinical experience, rather than evidence. Many also noted that patients with CAP seek reassurance, often afraid of recurrence upon hospital discharge.

Conclusion Doctors have mixed views on the current management of patients with CAP following discharge. Many concurred that patients experience anxiety and morbidity associated with recovery from CAP. Also, a perceived deficiency in the support infrastructure for affected patients was noted. Thus, further research could consider post-discharge management and recovery, in order to improve existing clinical recommendations and resources.

P34 PARAMEDIC TRAIL BLAZERS – WHY DO PARAMEDICS TAKE PART IN PREHOSPITAL RESEARCH?

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Background Research to improve prehospital treatment and care requires the participation of clinical and managerial staff from ambulance services to test interventions and collect research data. Researchers work closely with individuals and organisations with prehospital clinical, managerial and policy expertise to plan, deliver and disseminate research evidence. A recent trial involved assessing feasibility of paramedics administering Fascia Iliaca Compartment Block (FICB) in place of morphine to patients with suspected hip fracture. Participation in the trial was voluntary. We explored paramedics' motivation for participating in research through the RAPID (Rapid Analgesia for Prehospital Hip Disruption) trial.

Methods We held three focus groups with 11 RAPID trial paramedics serving one district hospital, audio-recorded with participants' consent. We conducted thematic analysis of interview transcripts. Two researchers, one paramedic and one lay member were in the analysis team.

Results Paramedics believed their participation in research had benefits for patients, for them individually and for the paramedic profession. Respondents said that being part of a research project provided an opportunity to increase their skills and provide improved patient care. In the RAPID trial, they understood the potential risks and benefits of different medications and management for patients with suspected hip fracture and welcomed the chance to identify improved pain management for a vulnerable population. They felt proud to be learning and using a procedure usually administered by clinical staff: *'This is quite specialised, like, hang on, I'm doing a really top job here, dealing with anaesthetics...blunt needles... it's like 'up there'. It's not our everyday thing.'*

More generally, respondents identified how research potentially contributed towards widening the scope of paramedic practice by extending their role into clinically specialist areas. They suggested that many paramedics were unwilling to undertake tasks perceived to exceed their pay-grades and shunned the opportunity to learn new techniques which were

not routine care. In comparison, these paramedics saw themselves as trail-blazers for the profession, proud to be acquiring extra clinical responsibilities and skills. They also valued the chance to contribute to the evidence base, providing knowledge about using alternative medication which they instinctively felt would cause fewer complications and benefit patient mortality and morbidity.

Conclusion Paramedics who take part in research believe they contribute to personal and professional development and potentially improve patient care. Future research with paramedics refusing research participation could explore barriers and different views on skills development, which may also inform implementation of new evidence-based interventions.

P35 IS THE STORY ABOUT WORRYING WOMEN AND STOICAL MEN TRUE? GENDER DIFFERENCES IN SUBJECTIVE HEALTH AFTER ADJUSTMENT FOR REPORTING STYLES

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Background Although women are less healthy than men with respect to physical health and depression, gender differences in morbidity and self-rated health (SRH) are less consistent. Female disadvantage in SRH has been partially explained by women's preponderance to report poor health. Although more recent studies challenge gender stereotypical treatment-seeking behavior and reporting of specific health conditions, we know relatively little about gender differences in reporting of SRH. The present study investigates to which extent adjusting for differences in reporting styles modifies gender differences in SRH, whether these changes are due to gender-specific over- and/or under-reporting patterns, and whether these changes are consistent for reporting of poor and good health.

Methods We utilize the data collected in the wave 1 (2004) of the Survey of Health, Ageing and Retirement in Europe, a multidisciplinary panel survey of community-dwelling individuals aged 50+ in 12 countries. The analysis follows the method proposed by Jürges (2007) and Rebelo and Pereira (2014). Our dependent variable is a global evaluation of health 5 possible responses: excellent, very good, good, fair, and poor. SRH is our dependent variable and is modelled with a generalized ordered probit model. There are two types of independent variables: latent health (e.g. chronic conditions, physical limitations, and smoking) variables and threshold variables (gender, education level and country). Once the appropriate model is selected and fitted, health indexes and disability weights are calculated. They, in turn, are used to calculate SRH adjusted for reporting styles.

Results Our preliminary analyses suggest that when SRH is adjusted for differences in reporting styles, the gender gaps in the percentage of persons with both poor and good widen. Except the oldest age group, more men have reported poor health than they have, whereas less women have reported poor SRH than they have except the youngest women. These findings suggest that men over-report and women under-report poor health. At all ages less men have reported very good